Commentary

Canada's Experiment With Health Insurance
Somewhere Over the Rainbow?

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These are stirring times for Canada. Politicians who have provided government-financed health insurance to all Canadians for more than 30 years are looking for politically acceptable ways to trim the health care system. There are even suggestions for a two-tiered, American-style system wherein people with more money get better medical care than the poor.

The outcome has implications not only for Canadians but for those Americans, including some in Congress and some groups of physicians, who believe that Canada's system holds the ideal solution to our own problem of rising health care costs and millions of citizens without health insurance.[1]

A case in point is Alberta, where the government is seeking ways to trim its budget. Albertans have enjoyed access to first-class medical care for years under Canada's publicly financed health care system, which is administered by the ten provinces with shared federal and provincial financing. But the costs have been rising at such a rate that three years ago Alberta's government was reported to have spent more than $3 billion, or almost a third of its entire budget, on health.

Faced with a spiraling provincial debt of more than $11 billion, the government set up a commission to figure out how to cut costs, with health care being the obvious target. The health future of Albertans is now the subject of a 370-page document aptly titled *The Rainbow Report: Our Vision for Health.*[2] The result of a two-year project by the Premier's Commission on the Future Health Care of Albertans, the report does not propose a departure from the present system of government involvement, but it strongly suggests measures that some believe depart from the original philosophy of Canadian government-sponsored care of equity and equal access to one that is more reminiscent of US policies.

By exercising regularly and eating properly, the report begins, Albertans can spend less time and money in hospitals and seeing their physicians. Before Canada had national health insurance, Albertans were self-reliant and uniquely able to cope with matters of their health. That national characteristic can be tapped again. The commission suggests that the government divert an additional 1%, or $30 million, of the provincial health plan's annual operating budget to programs of health promotion and the prevention of illness and injuries by 1995. It also recommends that secondary schools and universities become "role models for a healthy environment and practices" in the province.

Individual Budgets on 'Smart' Cards

To encourage an efficient use of the health system, the commission proposes that every subscriber to the Alberta Health Care Insurance Plan be given a specific annual health care budget based on his or her previous use of the system. Subscribers should also be issued "smart" cards containing a computer microchip on which their medical histories and personal health care allotments for the year would be electronically imprinted. When a subscriber visits a physician, an assistant would pop the card into a computer and read when the patient's last visit was, which tests were done, and what the physician prescribed, as well as how much money the patient has left in his or her government health care account. Those overspending their yearly allotment would be referred for counseling, while those using the system less than expected would get some kind of a reward. Such a system could decrease health care use by as much as 30% if smart cards were available, its proponents claim. Regarding extended health care services—home care and costs from chronic disabilities—the commission suggests that they be covered by direct government payments to patients to help reduce barriers and restrictions while "encouraging self-reliance and dignity." Such direct payments will require enabling legislation, however, which the commission suggests be put in place no later than 1993.

The commission thinks Alberta's health system is administratively unwieldy and that there is an urgent need to alter it. Currently, this involves more than 400 provincial boards and committees. The commission proposes to divide the province into nine autonomous administrative areas, with elected boards of trustees looking after the distribution of government funds and community care programs and facilities. In addition, the commission calls for the creation of a position of "Advocate for a Healthy Alberta." The advocate, with a $4.5 million annual budget, would conduct assessments of the health system and propose health care strategies.

Recommendations also include the establishment of a provincial ethics authority or center to provide grants to persons working on controversial medical issues such as organ transplantation, reproductive technologies, genetic medicine, and euthanasia. The commission thinks the government should initiate legislation to provide members of the public with the tools to make personal, financial, and legal arrangements before becoming incapacitated by major illness.

The report contains key recommendations for improving the well-being of care givers. They are intended to help ease the stress on the health care system's work force by encouraging management practices that recognize meritorious service, involvement in decisions regarding the provision of health services, programs directed toward resolving conflict, and incentives that create a safe working environment and

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good morale. Coupled with these measures is the need to monitor and evaluate health personnel requirements in the province to respond to the changing demands of patients and to relieve the stress on overworked, overextended health care professionals.

Emphasizing health promotion research, the commission asks that $33 million be allocated to the Alberta Heritage Foundation for Medical Research, dispersed over ten years, for studies in promoting healthy life-styles. In addition, it recommends an expanded mandate for the Alberta Research Council to evaluate the pros and cons of new health-related technologies, to develop strategies for distributing or rejecting technologies, and to assist, in conjunction with the private and public sector, in the successful transfer and marketing of Alberta-developed technologies.

Another provision concerns the environment. The government should expand the mandate of the Environment Council of Alberta, the commission says, to encourage greater research into environmental protection and the commercial production of "environmentally friendly" products.

Criticisms—'Dangerous Ideas, Glaring Omissions'

In the three volumes and 21 recommendations of the *Rainbow Report,* critics envision a hidden agenda to limit Albertans' access to health care. Despite public reassurances by commission chair Louis Hyndman that the report "strives to set the stage for the 21st century," critics charge it contains dangerous ideas and glaring omissions (K. Sherlock, "Brave New World of Medicine: Critics See Dangerous Ideas, Glaring Gaps in Rainbow Report," *Edmonton Journal,* February 24, 1990, p G1).

The report fails, they say, to offer concrete mechanisms for attacking one of the most important issues: the link between poverty and ill health. Similarly, mental health services are threatened because, like chronic diseases, psychiatric problems and their duration cannot be predicted, so it is ludicrous to penalize people for exceeding their health budget allotment. People should not be discouraged from visiting their physician, critics say, because early detection and treatment of an illness can prevent more serious and costly measures down the road.

What has generated the most heat from various sources is the recommendation that for the first time supplemental health insurance be routinely available to Albertans who wish to pay for and receive coverage over and above the basic services covered by the Alberta Health Care Insurance Plan. In addition, the commission proposes that alternative care givers such as native healers and herbalists be included in either the basic or supplemental plan. These recommendations, obviously aimed at saving the government money, mark a significant departure from the past policy of equity and equal access to medical care for all Canadians. Iglehart and Evans have pointed out that over the years Canada has refused to allow private insurance to be sold, except for incidental items not covered by the provincial plans, and that this reluctance arises from a deep-rooted suspicion of class-based systems.[3,4] The suggestion seems also totally out of character if one considers that Alberta is not just any province. With oil resources, rich agricultural and timber industries, tourism, and more than 50,000 people working in some area of health care, it is considered one of the richest in Canada (B. Hutchinson, "The Hyndman Manoeuvre: The Rainbow Report Looks to Save a Pot of Gold with a Streamlined Health Care System," *Alberta Report,* February 26, 1990, p 42).

Physicians Fear Risk of Two-Tiered System

In press statements, Ronald Gregg, MD, past president of the Alberta Medical Association, and Richard Plain of the Alberta Consumer Association have both praised but also criticized the report (K. Sherlock, *Edmonton Journal,* February 24, 1990, p G1). They said it opens the risk of a two-tiered system because it leaves the definition of basic services up to the government of the day, and the government has a record of trying to cut coverage for some services to save money. Alberta physicians are worried about cost-conscious governments deciding what is necessary. Instead, Gregg and others think society as a whole—not physicians or government alone—must, after complex calculations, define which services are appropriate for which types of patients and thus eligible for public financing. As costs continue to rise, physicians agree that new medical procedures will have to be examined objectively. The commission prudently did not define "basic" services; it has left the job of doing so to the politicians.

The Canada Health Act does not define "basic" or "medically required" health care, and this results in differences in services between provinces. For example, some provincial health plans now cover in vitro fertilization, but this procedure is not covered in Alberta. Such gaps in coverage have led to what the Alberta Medical Association describes as at least four tiers of care now available to Albertans. They include the Alberta Health Care Insurance Plan as it exists; those with supplemental coverage, such as Blue Cross, often enjoyed by labor union members; privately run clinics providing services such as eye and cosmetic surgery; and the United States—where wealthy Canadians or those who have saved their money for such purposes can receive treatment either not available in Alberta or Canada or for which there is an undesirable waiting time. Basic health services, according to the association, must be of high quality and ensure comprehensiveness, portability, universality, accessibility, and public administration. For services not defined as basic, Albertans must have the right to purchase coinsurance.

Although the Alberta Medical Association agrees in principle with many of the recommendations of the *Rainbow Report,* it has criticized the report for its "middle-class, if not an upper-middle-class, bias of what the future may be."[5] The report, the Association notes, makes only a passing reference to the spectre of poverty in the midst of above-average incomes, while "the salient reality is that people's health remains directly related to their socioeconomic status." A better approach would be for the health care system to evolve more comprehensive strategies to address the needs of different groups of society on a priority basis.

In supporting health promotion as a worthwhile goal, the association's analysis raises doubts that those Albertans who live at or near the poverty line can be expected to pursue a healthy life-style. Health promotion has its biggest payoff with children, the association states, and health goals specific to children and adolescents, such as improving diet and fitness and reducing smoking and teen pregnancies, should be considered. It recommends a greater emphasis on reducing workplace injuries and automobile accidents while cautioning that health promotion is not a financial panacea. "The financial impact of any positive life-style changes is

unlikely to be forthcoming for at least two decades (much longer than the tenure of most governments)."[5] The association also supports the intent of the recommendation on smart cards but has questioned their practicality and cost-effectiveness on grounds that they may become "cards of regulation" rather than cards of information. Another association concern is the recommendation for rewarding those who use the health care system considerably less than the norm. Actually, it will tend to reward those with upper-middle-class and upper-class life-styles and penalize those from the lower socioeconomic groups who suffer from poor health, including many accident victims who often require prolonged, expensive medical care through no fault of their own.

Because of the reaction to the commission's report, which has ranged from praise to outright indignation, Premier Donald Getty has asked an interdepartmental committee of the Ministry of Health to study the recommendations and develop a policy statement for their implementation. A ministry spokesperson said flatly that the government has no intention of moving toward a two-tiered system. In fact, four years ago, Alberta tried legislation that would have allowed private insurance companies to compete with the Alberta Health Care Insurance Plan. A public outcry compelled Mr Getty to withdraw the legislation. In a similar move, the province removed insurance coverage of several procedures, including tubal ligations, cosmetic plastic surgery, circumcision, and contraceptive counseling. After public complaints, coverage of some of the services was reinstated. It should be noted that Alberta is still the only province to consider a two-tiered approach as part of the solution. Recent inquiries in Ontario, Quebec, Nova Scotia, and New Brunswick indicate that these provinces have been thinking of ways to cut costs but have not broached the subject (C. McLaren, "Alberta: The Spectre of Two-Tier Medicare," *The Globe and Mail,* March 17, 1990, p D1).

Government insurance was introduced to Canada in four phases. First came hospital construction in 1948, followed by hospital insurance in 1958 and health personnel development in 1965. Finally, medical care insurance was started in 1968 to cover physicians' costs. In providing universal coverage, Canadians were motivated mainly by human concerns rather than economic objectives.[6] Their purpose was to remove barriers to health care. They decided that coverage had to be comprehensive, meaning it would pay for all medically needed services rendered by physicians or hospitals without limit. They determined that benefits would be portable when people moved from one province to another and that health insurance had to be operated on a nonprofit basis by public agencies accountable to the people.

Reduced Federal Cash Transfers Hurt Provinces

The system, which initially promised so much, has come under hard times, for many reasons. Canadians are aging. Their economy is growing at a slower pace. Hospitals within various regions are duplicating services, and provincial health care plans' payments to physicians are rising, with health services now gobbling a third of every province's budget. For a time in the late 1970s, Canada seemed to be succeeding in slowing the rise of health care costs through various measures. These involved closing surplus hospital beds, eliminating unnecessary services, and establishing a system of prospective payment for hospitals and negotiated fees for physicians. Even these measures are now deemed insufficient. Like Alberta, the federal government in Ottawa has stepped up its policies. In an attempt to reduce Canada's federal deficit, Prime Minister Mulroney's government has twice now, in 1986 and 1989, reduced the contribution of federal government funds to provincial plans. This is done by a new formula based on the growth rate of a three-year running average of the gross national product, minus three percentage points. Canada's gross national product, however, has been declining for three years in a row, and as Iglehart recently predicted, this decline is having a cumulative effect on provincial budgets.[3]

Specifically, federal money transfers from Ottawa to the provincial health insurance plans declined from 44.6% in 1979 and 1980 to 36.7% in 1989 and 1990 and are likely to continue to fall as a result of a new policy initiated by the federal finance minister as part of the 1990 federal budget. Under special legislation (Bill C-69), the per capita federal transfer payments to the provincial health insurance plans were frozen at the 1989-1990 level for two years. In the most recent, February 26, 1991, federal budget, the finance minister announced that this freeze would be extended for another three years. Because the original formula provides for both a tax transfer and a cash transfer, the freeze in total per capita transfers means that federal cash payments to the provinces are in fact being reduced, according to Bill Tholl, director of Health Policy and Economics of the Canadian Medical Association. "Federal cash contributions for some provinces are expected to drop to zero as early as 1994-1995," Tholl adds, "and in the absence of corrective legislation, this means that the national health insurance principles set out in the Canada Health Act will become unenforceable" (written communication, April 1991).

Tholl predicts that reductions in federal cash transfers can be expected to have a differential effect across the provinces depending on any number of factors. Chief among these is the "fiscal capacity" of a province. Poorer provinces such as Newfoundland with limited ability to generate additional tax revenue will have difficulty making up for the shortfall and have already announced major cuts in health programs. The richer Canadian provinces, such as Alberta, with a fiscal capacity 25% to 30% higher than that of any other province, are thought to have considerable fiscal flexibility and untapped potential to raise additional tax revenues necessary to offset the federal reductions. Alberta's $3.2 billion provincial health budget was scheduled for an increase of only 3% in 1990; public pressure eventually forced an increase of 4.1%, which is still below the projected level of inflation. The recent cuts in federal transfer payments have only added to the difficulty, which is being offset by an 8% increase in the provincial health care budget for 1991.

Problems with the Canadian system are documented in almost daily news accounts both in Canada and the United States. In Montreal, for instance, where provincial authorities had set a temporary cap on physician fees, many physicians decided to take two-week vacations every quarter, and hospitals shaved their budgets by holiday closings of wards and operating rooms. Patients backed up in the emergency departments, and one official of the Quebec Medical Society was quoted as saying, "We think the system is breaking down."

Some observers think these "horror" stories are exaggerated, and they cite the well-known tendency of the health care

sector to bleed profusely in the face of financial hits. Robert G. Evans, a Canadian health economist quoted in the *New York Times,* thinks the rhetoric of underfunding, shortages, and excessive waiting lists is now an important part of the process by which Canadian health care providers negotiate and gain their share of public resources—and their incomes (M. Freudenheim, "Debating the Canadian Health 'Model,' " *New York Times,* June 29, 1989, p C1). Another view maintains that because the government's control over payment is the principal means of regulating health care use, Canadian hospitals are forced to hold their costs below the available revenue to remain solvent. Faced with insufficient resources, hospitals resort to rationing services through queuing.[7(p15)] Patients are put on waiting lists for available hospital beds or for certain types of medical procedures or are literally lined up in hospital hallways awaiting care. In effect, Canadian providers decide who receives care and who does not by comparing the needs of each patient relative to all other patients. "The name of the game is to put your patient on as many lists as you can," one Canadian hospital official notes, "and whichever comes first, you admit your patient there."[8(p26)] Information collected by one Canadian public policy research organization suggests there are long waiting lists throughout most of Canada for laboratory tests and for high-cost surgical procedures such as hip replacements, cataract removal, and heart bypass procedure (J. Kosterlitz, "Taking Care of Canada," *National Journal,* July 15, 1989, p 1796). A related issue is the effect of cost containment on the diffusion of technologic innovation because of restraints on funding for capital acquisitions such as magnetic resonance imaging, lithotripsy, and organ transplantation.

Differences of opinion on such issues may reflect, of course, different views on the importance of state-of-the-art medicine in Canada and the US and may also reflect different medical practice philosophies. But figures, whether measuring the number of facilities offering various technologies or the number of persons that each facility serves, suggest that access to expensive technologies in Canada may be impeded.[9] An example cited is that in 1989 Canada had a total of four lithotripters in the entire country and at least one US hospital was receiving the overflow. In the first five months of that year, half of all lithotripsy patients at New York State's Buffalo General Medical Center were Canadians.[7(p16)]

While the Canadian system still has much to recommend it—no one is seriously thinking of abandoning it—developments in Alberta are throwing a spotlight on a key question now troubling policymakers in Canada, the US, Great Britain, France, and other developed countries: how much health care is enough, and which medical services will be considered essential and eligible for payment from government or private insurers in the future? Economic stagnation, coupled with world tensions and increasing military expenditures, has rendered the continued expansion of health care outlays unacceptable throughout the western nations. Austerity measures in health care will differ from one nation to another, depending on the political group in power and the degree of opposition in place. In fact, one political observer predicts a sharpening of ideologic cleavages in all policy areas, with a loss of public confidence in government emerging as the most important single issue in the future.[10] This is another reason why recent developments in Alberta are instructive.

It is clear thus far that Alberta's past attempts to ration health care, which is regarded as a basic right, have met with mixed success, and there is no reason to think that the most controversial recommendations of the *Rainbow Report,* if implemented, will fare any better. In each instance in the past, as in the example of cosmetic surgery, tubal ligations, and circumcision that were removed from insurance coverage, politicians had to acquiesce to public opposition by restoring coverage to avoid the destabilizing political repercussions. In fact, after a two-year review of the report, the government in January 1992 announced it had decided it will not implement several key recommendations it felt Albertans would perceive as undermining universality. These included the recommendations for smart cards, supplementary insurance for optional services, the appointment of a health care advocate for Alberta, and the reorganization of regional health authorities. To their credit, physicians' organizations have effectively reacted against the system and criticized it when the government's efforts to save money were in direct conflict with the interests of their patients. Canadian physicians seem able to mount an effective front against austerity efforts, and by their actions they also protect their incomes.

As for those Americans with a fascination for the Canadian approach, one thing is clear. It is not a panacea. Apart from better efficiency and fiscal control, as well as more equitable accessibility, Canada's system has left many issues unresolved. If the United States were to adopt a plan substantially the same as Canada's, there is no significant reason to expect that the US experience would be different in this respect. It is nevertheless a system whose continuing evolution is worth watching for those political lessons that are applicable to the US.

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